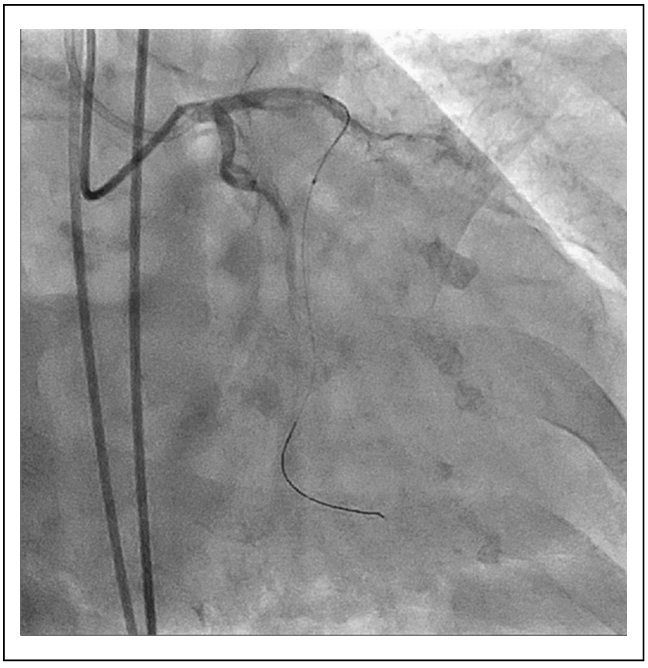
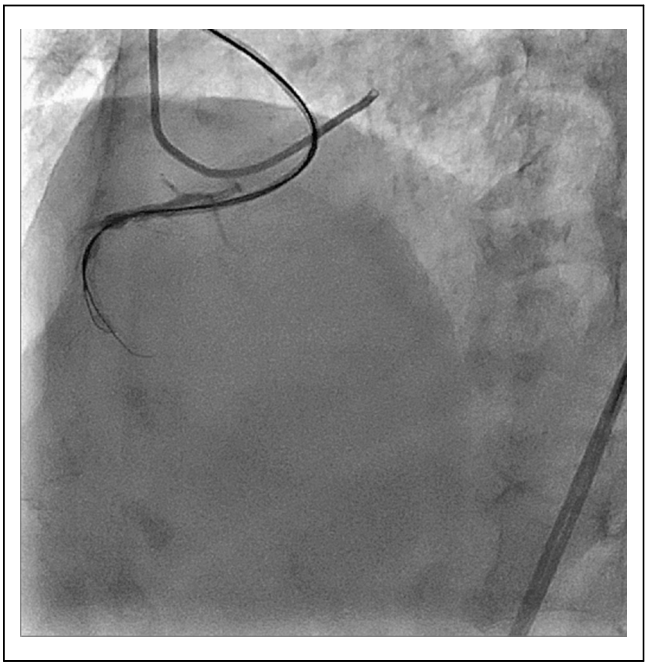
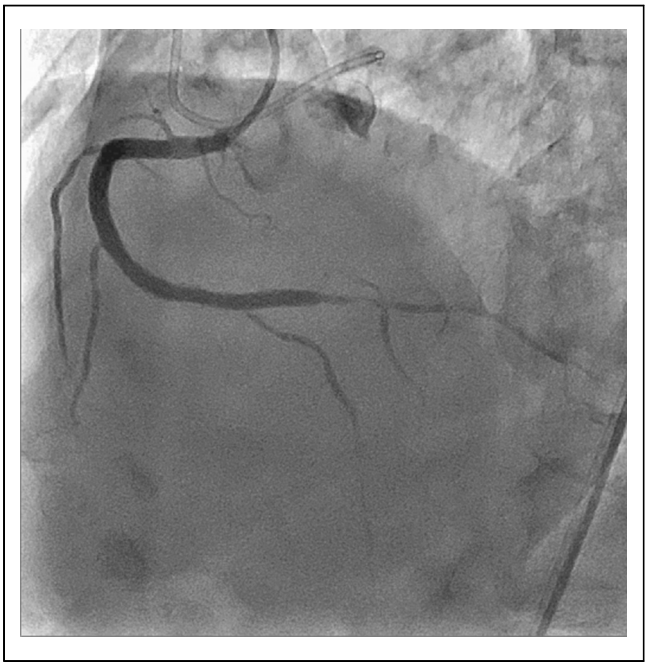
balloon catheter (Asahi) and dilated whole length of the lesion. After three Nobori stents (3.0-28 mm + 3.5-28 mm + 3.5-28 mm) (Terumo) were placed, we performed postdilatation using a 3.75-13 mm Kunai balloon catheter (Asahi). Final angiography revealed that the lesion was well dilated without any complications.







Case Summary. It is well known that bi-directional procedure using intra-coronary collateral channels is of much effect to treat chronic total occlusions. In those situations, thick guiding catheters are widely used. But 5 Fr Ikari Left guiding catheters have good maneuverability and can be used to engage not only left but also right coronary arteries from whichever approach is selected. Deep engagement of 5 Fr guiding catheter is safe and can be easily performed, and it enables us to achieve strong back up force and perform various techniques including parallel wire technique.

TCTAP C-100

Successful Retrograde Externalization of a Left Anterior Descending Artery Chronic Total Occlusion with Landmark of a Previous Placed Diagonal Artery Stent

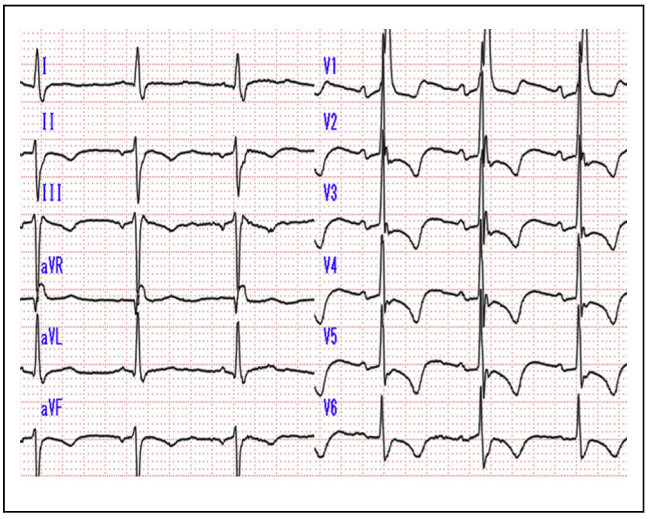
Ryota Sato[1]

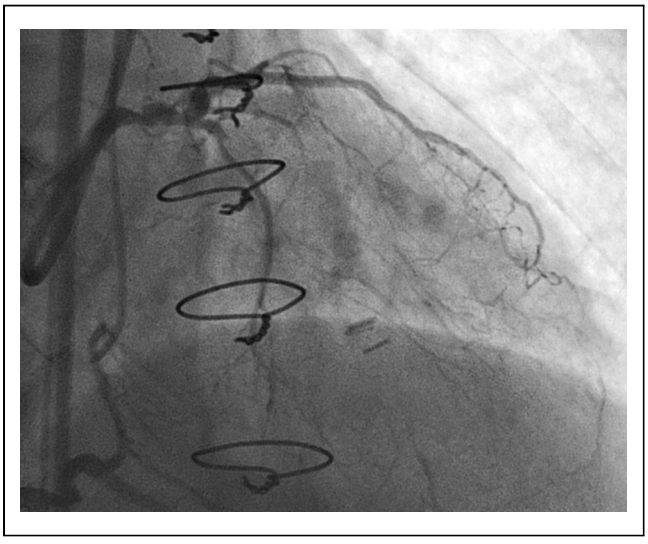
[1]Seirei Mikatahara General Hospital, Japan

[CLINICAL INFORMATION]

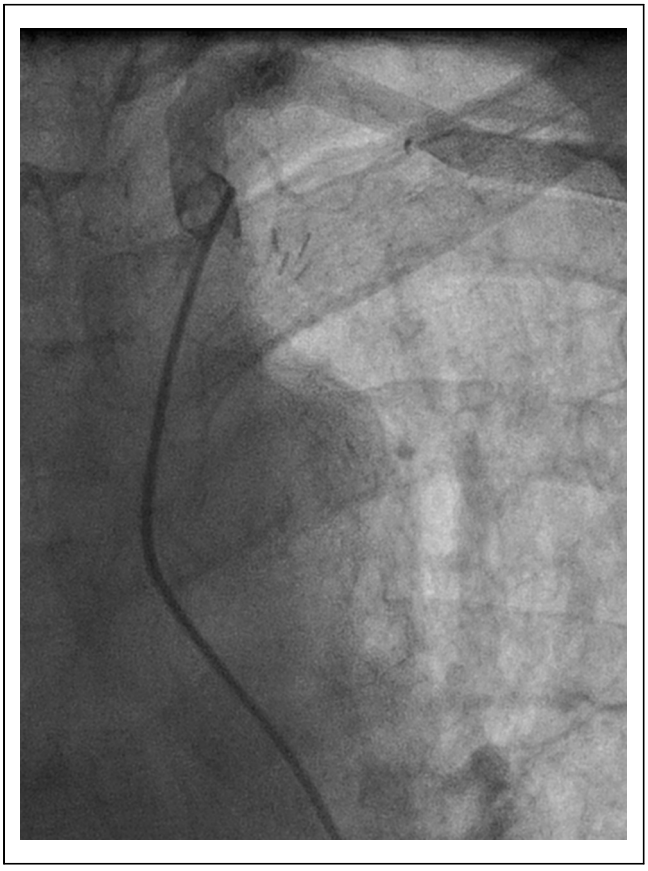
Patient initials or identifier number. 98982777

Relevant clinical history and physical exam. A 70-year-old male had unstable angina pectoris. Coronary angiography revealed total occlusion in ostial left anterior descending artery(LAD), 90% stenosis in left circumflex artery(LCX), and 99% stenosis right coronary artery(RCA). The patient had undergone emergent coronary artery bypass graft(CABG); left internal thoracic artery(LITA) to the LAD, saphena vein graft(SVG) to the LCX, and SVG to the RCA. In the first post-CABG year, he was admitted to our hospital because of exertinal chest pain.





Relevant test results prior to catheterization. Coronary Computed to mography showed two grafts (LITA to LAD and SVG to RCA) to be occluded.

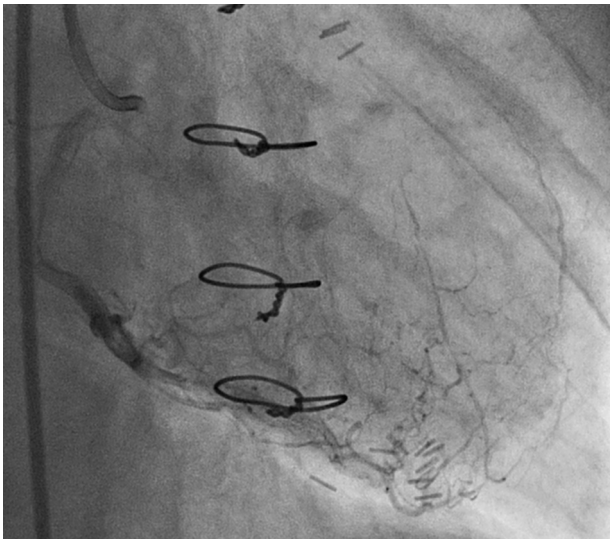


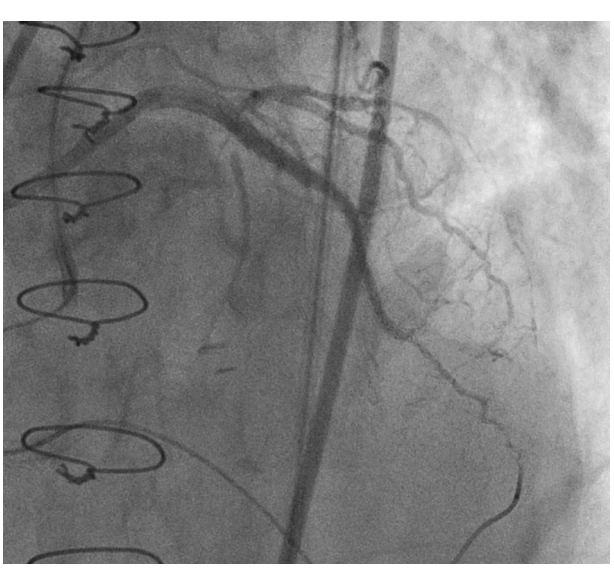
Relevant catheterization findings. Repeat angiography showed two grafts (LITA to LAD and SVG to RCA) to be occluded. The distal LAD and diagonal artery were filled via right-to-left collaterals from septal of the posterior descending artery (PDA).

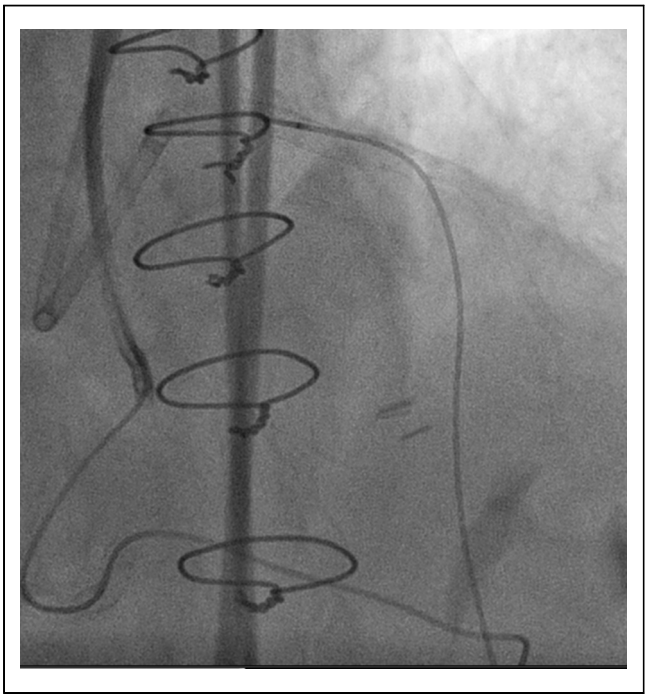
[INTERVENTIONAL MANAGEMENT]

Procedural step. First, we performed successful percutaneous coronary intervention (PCI) in RCA. After three months, we managed to attemptr ecanalization of LAD chronic total occlusion (CTO) using the retrograde approach via the septal collateral from the PDA. Because we thought that a guide wire was successfully directed into the septal perforator toward the LAD, the lesion of the LAD to left main trunk (LMT) was dilated and drug-eluting stents was implanted. But final

angiograms showed stents which extended from LMT into the diagonal artery. After three months, we decided to attempt recanalization of the mid LAD CTO using the retrograde approach via the septal collateral from the PDA. Multiple selective contrast injections from microcatheter were performed to select the septal collaterals which were different from the previous. As we managed to advance a guidewire and a channel dilator to the distal cap, we penetrated the distal cap of the occlusion and inland mark of a previous placed diagonal artery stent. After externalization, the mid LAD was dilated and drug-eluting stents was implanted.







Case Summary. We experienced one case of successful retrograde externalization of a left anterior descending artery (LAD) chronic total occlusion, because we used the landmark of a previous placed diagonal artery stent.

TCTAP C-101

CTO PCI for LAD in Multi-Vessel Lesions Case

Mahmoud Mohamed Soliman[1]
[1]CMC, Egypt

[CLINICAL INFORMATION]

Patient initials or identifier number. Mr. A

Relevant clinical history and physical exam. 68 years old male patient

Compliant from typical chest pain at rest with optimal medical therapy

cvRF: Ex-Smoker, Hypertension, Diabetic

P H: Inferior MI and received SK at 2008

ECG: Pathological Q in Inferior Leads and ST depression in V4-V6, AVL

ECHO: LVEF 48%, Hypokinesia in the Apical, Anterior and Lateral Walls.

Index Coronary Angiogram: 3-vessel disease. Total LAD and Subtotal LCX and mid-segment RCA

[INTERVENTIONAL MANAGEMENT]

Procedural step. We use 6FGuiding Catheter

Pilot 200 wire and Maverick balloon 2.0x20 mm

we have dissection after good dilatation we use Xience DES 2.75x 38 mm and Nobori 3.0x 28 mm DES